

- An Evidence-Based Practice (EBP) Model that would bring NC to national averages for treated prevalence across populations and increase the continuity of service, thereby allowing for a significant reduction in State Facility use, and a
- A Defined Benefit model that originally was designed to reduce state cost or contain them by limiting the scope, amount and duration of service. The State preferred, for this initial presentation, to limit service eligibility requirements rather than the scope, amount or duration of service.

The Actual Model is based on actual claims data for FY 2005. The second Model reflects an “Evidence Best-Practice” approach where the scope and intensity (frequency and duration) of service was based on research reflecting best- practices; community-based service packages that honor self-determination, family resiliency, recovery principles, and cultural sensitivity for target populations. This scenario reflects what it would cost if all desired services were provided with the appropriate intensity.

Alone, Best Practices might be impossible for the State to fund. However, coupled with an incentive base to limit state hospital use by providing sufficient community based services and recognizing the fact that many of the community based services would result in increased Federal share as best practices were increased in the community, the State’s cost could be reduced significantly. The Models “phase in” EBP services while reducing those services that are not as effective until the ideal state is reached in 2010.

The Best-Practice Model was utilized as the basis for projecting costs, based upon start-up, phase-in and correction of gaps, including goals the State has for increasing prevalence and implementing evidence based practices. While best practices reduce state hospital use, there is a direct significant positive correlation between increased treated prevalence and admissions to state hospitals. This could explain in part why the State has seen more state facility admissions but reduced bed days. Often people entering the system require immediate inpatient care that may not ever be repeated or may be for a short duration. Alternatives are needed at the front door. For each year, 2006, 2007, 2008, 2009 and 2010 the EBP model demonstrates what it would cost NC if all desired services were provided with the appropriate intensity.

In the “Defined Benefit” scenario, the Model has been initially populated to calculate costs on a sub-set of the target population rather than on the scope, amount or duration of service. Reduced scope, amount and duration are also options but are not favored by Division staff given consumer movement between Medicaid and General Revenue benefit plans. When the likelihood is apparent that an individual will qualify for Medicaid, they should be started in appropriate services that will later be available through the Medicaid Plan. When it is clear because of the lesser degree of disability or an income status that prevents an individual from qualifying for Medicaid, they must meet restricted eligibility criteria. In many cases this may include assessment only to rule out significant disability that would qualify the individual as a member of the “Target Population”. Several assumptions are made including the fact that a percentage of consumers will